

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH'57 021234
STATE FILE NUMBER
2740

FILED JUN 28 1957

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

300 0
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General #2		d. STREET ADDRESS 1900 E. 11th	
3. NAME OF DECEASED (Type or print) First Wanda Middle Lee Last Miller		4. DATE OF DEATH Month June Day 6, Year 1957	
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1926
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Curtis, Arkansas	
13a. FATHER'S NAME Will Box		14. NAME OF HUSBAND OR WIFE Alex Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple internal injuries, extent undetermined, Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Toxic psychosis DUE TO (c) Myelogenous leukemia		17. INFORMANT Address James Williams, brother 1415 Harrison	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6978X ^H	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Jumped from 3rd floor window	
20c. TIME OF INJURY Hour 3:20 p.m. Month, Day, Year 6-6-57			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Gen. Hosp. #2	
20f. CITY, TOWN, OR LOCATION Kansas City		COUNTY Jackson STATE Mo.	
21. I attended the deceased from Death occurred at 5-11-57 to 6-6-57 and last saw him alive on 6-6-57			
22a. SIGNATURE M. R. Peterson (Doctor or title)		22b. ADDRESS 600 E. 22nd Street	
22c. DATE SIGNED 6-11-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-12-57	
23c. NAME OF CEMETERY OR CREMATORY -		23d. LOCATION (City, town, or country) (State) Arkadelphia, Arkansas	
24. FUNERAL DIRECTOR Watkins Bros. Fn. Hm. 18th & Benton Blvd.		25. DATE RECD. BY LOCAL REG. 6-11-57	
26. REGISTRAR'S SIGNATURE Irene Marshall			

(Licensed Embolmer's Statement on Reverse Side)

W. R. Peterson
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer _____

Signed _____

Licensed Embalmer No. 4500

P. O. Address 15th & Ben

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.